STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155472	A. BUILDING 00 B. WING	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER VILLAGE	9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. This visit included the investigation of Complaint IN00102945. Complaint IN00102945: Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F248. Survey dates: January 23, 24, 25, 26, and 27, 2012 Facility Number: 000548 Provider Number: 155472 AIM Number: N/A Survey team: Janet Stanton, R.N.--Team Coordinator Rita Mullen, R.N. Michelle Hosteter, R.N. Heather Lay, R.N. (1/23, 24, and 25) Census bed type: SNF--13 NCC--60 Residential--73 Total--146 Census payor type: Medicare--11 Other--135 Total--146	F0000	This Plan of Correction constitutes the written compliance for the deficiences cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 8 NCC sample: 4 Residential sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 1/31/12 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to ensure the attending physician was notified about a change of condition for 1 of 1 residents who developed swelling and pain in the right lower leg, was sent to the hospital and diagnosed with DVT [deep vein	F0157	1. The facility considers the nurse's decision to write a note in the physician's book and reporting to oncoming nursing staff to monitor Resident D's edema through the evening and night of 12/25/12 appropriate. The nurse practitioner was informed of the increase edema the	02/17/2012

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	thrombosis--a blood clot]; in a sample of 8 residents reviewed. [Resident #D] Findings included: The closed clinical record for Resident #D was reviewed on 1/25/12 at 10:15 A.M. The resident was originally admitted to the facility on 11/16/11 with diagnoses which included, but were not limited to, recent history of a urinary tract infection, dementia, emphysema, debility, hypertension, and congestive heart failure. A "Daily Skilled Nursing Assessment" progress note, dated 12/25/11 at 8:00 A.M. indicated the resident had no edema, with bilateral pedal [foot] peripheral pulses present. On the reverse side of the assessment progress note, a subsequent "Nurse's Note" at 5:00 P.M. indicated "RLE [right lower extremity]--Skin shiny, tight, foot with 2+ pitting edema. Had been in recliner this afternoon with foot elevated...." Another note at 7:30 P.M. indicated "... 2+ edema noted in right lower extremity/foot. Has had a 1 pound weight gain tonight from previous day." There was no documentation that the attending physician had been called to notify about the sudden edema in the		morning of 12/26/12 and the resident was sent to the emergency room for evaluation. Furthermore, Resident D's family was present the evening of 12/25/12 and aware of the nurse's decision to leave a note in the physician's book rather than calling the physician that evening and did not verbalize disagreement with the decision made by the nurse. 2. No other residents were affected. 3. In an effort to ensure ongoing compliance, members of the Quality Assurance Committee (QA) and the Medical Director have reviewed and updated the policy for physician notification. A mandatory nursing in-service will be conducted on 2/14 and 2/16 to review the physician notification policy with all nurses. 4. As a means of quality assurance, the QA coordinator will audit monthly nursing documentation for appropriateness of physician notification. Audits will be reported to the Quality Assurance Committee to be reviewed in the quarterly meetings for the next 6 months. The Quality Assurance committee will then determine if ongoing review will be necessary.	

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	resident's right leg and foot. The "Daily Skilled Nursing Assessment" dated 12/26/11 at 7:00 A.M. indicated the resident had 3+ edema of the right lower extremity, with pedal pulses present. The "Comments" section did not indicate the physician was notified. On the reverse side of the assessment progress note, a subsequent "Nurse's Note" at 10:00 A.M. indicated "[Family member] concerned about edema right lower extremity. Explain [sic] no physician making rounds today but can call doctor on call." A note at 10:30 A.M. indicated "Received call from [name] Nurse Practitioner regarding right lower extremity edema. Edema is 3+ including calf. Examined--edema seems to have worsened according to past notes. Peripheral pulses present but weak. Returned call to [name] Nurse Practitioner." A "Nurse's Note" at 11:10 A.M. indicated "Called [family member] regarding permission to call ambulance.... [Ambulance company] notified for non-emergency transfer." The resident was transported to an acute care hospital at 11:30 A.M. A preliminary venous imaging report from the hospital, dated 12/26/11 at 2:27 P.M., indicated "... Impression: extensive right			

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	leg DVT [deep vein thrombosis--a blood clot] which extends into the right iliac vein." The resident returned to the facility at 4:45 P.M. with new physician orders for anticoagulant [blood thinning] medications. During the daily conference on 1/25/12 at 3:10 P.M., the Director of Nursing was given the opportunity to submit any documentation/evidence that the attending physician had been notified about the sudden swelling of Resident #D's leg and foot. On 1/26/12 at 10:45 A.M., the Inservice Director provided a copy of a physician's information log sheet. In an interview at that time, the Inservice Director indicated the nurses used the log to communicate with the physician about individual resident issues, with the issues written in the log book for the physician to review the next time she was in the building. One entry, dated 12/25/11, indicated "[Resident #D] right lower extremity/foot with 2+ edema (pitting) to foot--Skin shiny, tight." There were no initials or signature from the physician or Nurse Practitioner to indicate either one had reviewed the log or acknowledged the entry. In the interview, the Inservice Director			

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	indicated the nurses had not called the physician, but had put this note in the log book. She was not sure if the physician or Nurse Practitioner had come in the next day [12/26/11]. In an interview on 12/27/12 at 10:00 A.M., the Administrator indicated the facility had a policy related to physician notification. At the final exit on 1/27/12 at 11:45 A.M., the policy had not been provided for review. This Federal tag relates to Complaint IN00102945. 3.1-5(a)(2)			

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F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure individual activities were offered and provided to 1 of 4 residents who were required to be in contact isolation for a gastrointestinal infection; in a sample of 8 residents reviewed. [Resident #D] Findings include: The closed clinical record for Resident #D was reviewed on 1/25/12 at 10:15 A.M. The resident was admitted to the facility on 11/16/11 with diagnoses which included, but were not limited to, dementia, recent history of urinary tract infection, emphysema, hypertension, congestive heart failure, and debility. A "Daily Skilled Nursing Assessment" note, dated 12/8/11 at 7:00 A.M., indicated "[Family member] reports resident has history of loose stools. Had loose incontinent stool today--will report to Dr. [physician's name]...." A "Daily Skilled Nursing Assessment" note, dated 12/9/11 at 7:00 A.M., indicated "Three large loose stools	F0248	1. Resident D was admitted to Hoosier Village on 11/16/2011 for short term rehab. Resident D met her rehab goals and was discharged on 12/29/2011. 2. There were no other residents affected.3. On 2/6/2012 the activities staff were advised of the following: All room visits by the activities staff for each resident that is room bound, whether for contact isolation or other reasons, are to be documented. Based on the resident's assessement information and interests, a variety of items including puzzle books, magazines, cards, writing materials, games, etc. are to be offered during those visits and the resident's response documented. The Staff Chaplain will also be notified of any room bound resident and will visit if desired by the resident.4. As a means of quality assurance, the contracted activity consultant will audit activity documentation quarterly to ensure that the individual activities for residents that are room bound have been offered and the response documented. The consultant visit is scheduled on 3/22/12. The Director of Resident Services will present those audits to	02/10/2012

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	yesterday. New order for specimen for C-Diff [Clostridium Difficile--an intestinal infection]. Room set up for contact isolation...." The resident remained on strict contact isolation and confined to her room until 12/19/11. A "Daily Skilled Nursing Assessment" note, dated 12/19/11 at 7:00 A.M., indicated "... Assisted to toilet, dress, and ambulate to Whispering Pines [main dining room] with rolling walker.... 9:00 A.M.--Ambulated back to room with rolling walker with assist." An "Activities 14-day Progress Note," dated 12/15/11, indicated "... A.D. [Activity Director] was unable to assess resident as she is on contact isolation for C-Diff infection at this time. A.D. will continue to provide Resident with a Monthly Activity Calendar, invite and encourage Resident to participate in group activities when she is no longer on contact isolation and is able to participate...." An "Activities Assessment" dated 11/21/11 indicated had past and present interests in individual solitary activities of: Puzzles--crossword, jigsaw, word search; Movies--comedy, drama, musical, westerns, war, sci-fi, Disney; Television--news, sports, soaps, game shows, cartoons, classics; Crafts--crocheting,		the Quality Assurance Committee for the next 6 months. Ongoing audits will not be necessary if 100% compliance is met for the 6 months.	

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	needlepoint; Music--country, gospel, jazz, Big Band; Reading--fiction, non-fiction. In an interview on 1/26/12 at 1:35 P.M., the Activities Director indicated that during Resident D's contact isolation period, she would "pop-in" but stand at the door because she could not go into the room. She would "chit-chat" with the resident for a couple of minutes each day, and ask if there was anything she needed, or anything she could get that would make the resident more comfortable. In the interview, the Activity Director indicated she did not offer any specific activity, chosen from the assessment information list, that the resident could do in her room independently. The Activity Director indicated she did not keep documentation of any one-to-one activities offered. On 1/26/12 at 2:00 P.M., the Resident Service Director provided a copy of an individual December, 2011 activity calendar for Resident #D. She indicated the activities high-lighted in green indicated the resident had actively participated in the scheduled group activity. For the isolation period from 12/9 to 12/19/11, the December 2011 calendar indicated Resident #D received a "room			

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	visit" on 12/12, 12/15, and 12/17/11. From 12/19 to 12/28/11, no group activities were high-lighted to indicate the resident participated. Room visits were marked on 12/19, 12/21, 12/22, and 12/27/11. On 12/28/11, the day before the resident was discharged to an assisted living facility, "Bingo" was high-lighted to indicated the resident had actively participated in that group activity. This Federal tag relates to Complaint IN00102945. 3.1-33(a) 3.1-33(b)(8)			

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation and interview, the facility failed to date prepared food items that were to be served to Residents and failed to clean a Heat and Serve warmer, used the evening before. This impacted 1 of 1 kitchens and the potential to effect 13 of 13 Residents. Findings include: During the initial tour of the kitchen with the Director of Food Services, on 1/23/12 at 10:30 A.M., three trays of cookies were not dated and one tray of jello with fruit, stored in a refrigerator, was not dated. A Heat and Serve, used to keep soup warm during serving, had dried liquid on the outside of the equipment casing. During an interview with the Director of Food Services, on 1/23/12 at 10:35 A.M., she indicated the cookies and jello were to be served that day but should have dates and the Heat and Serve, used the evening before, needed to be cleaned. 3.1-21(i)(2)	F0371	1.The three trays of cookies were just baked, warm from the oven and had not had sufficient time to cool before individually wrapping and dating them, this was done later the same morning. The one tray of jello with fruit had been made the night of 1/22/12 for meal service on 1/23/12. The heat and serve warmer was used for service the previous evening meal. The food container had been removed and sanitized in the dishwasher the same evening. The outer casing was wiped clean prior to being used again. 2.There were no residents affected. 3. All dietary staff will be re-in serviced on the dating of prepared food items and the cleaning of equipment the week of February 13th-February 17th.4. As a means to ensure ongoing compliance, the kitchen supervisor or designee will monitor the cleaning daily and the Director of Dining Services or designee will audit the cleaning schedule weekly. All audits will be reviewed with the Quality Assurance Committee for the next 6 months. The Quality Assurance committee will then determine if ongoing audits will be necessary. Ongoing audits will not be necessary if 100%	02/17/2012

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			compliance is met for the 6 months.	

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F9999				
	STATE FINDINGS 3.1-28 STAFF TREATMENT OF RESIDENTS 1. (a) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property.... (c) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to investigate, failed to suspend a C.N.A. to protect residents, and failed to report to the appropriate state agencies an allegation about rough care given by a C.N.A.; for 1 of 1 residents reviewed for abuse investigations in a sample of 4 residents. [Resident #11]	F9999	1.) 1. Although the surveyors report states that "the facility failed to investigate, failed to suspend a C.N.A. to protect residents." a thorough investigation of the grievance from Resident #11 was conducted by Hoosier Village administrative staff the same day the resident voiced the complaint. Immediate action was taken. The identified C.N.A was not permitted to return to work after the complaint was voiced. Further, although the complaint was unsubstantiated by the investigation, the C.N.A. was subsequently terminated. As stated in the surveyors report, written documentation of the investigation was provided to surveyors on 1/25/12 at 8:45 AM.2. Per the facility policy, all grievances and allegations are investigated promptly once identified. As noted in the survey results, this is the only grievance made by any resident in the health center and Resident #11 remains in the health center and has not voiced any further concerns with her care. During the initial investigation of this grievance, the Director of Resident Services interviewed several other residents to address any concerns of care provided by the identified CNA and there were no concerns. Therefore, no other residents were affected. 3. As a	02/17/2012

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	Findings include: During the entrance conference on 1/23/12 at 10:30 A.M., the Administrator was requested to provide the facility policy and procedures related to abuse prohibition, and any allegations that had been investigated in the past 3 months to determine if the facility followed the policy and implemented the proper procedures. The Administrator was requested again at the daily conference on 1/24/12 at 3:10 P.M. for examples of any allegations of abuse that had been investigated. In an interview on 1/25/12 at 8:45 A.M., the Administrator indicated there were no reported allegations of abuse that had been investigated, but there were some grievances, which she provided for review. One of the grievances reviewed was submitted for Resident #11. The "Working Notes" indicated "... 10/20/11 [Resident #11] reported to [Nurse's name--L.P.N. #5] that the C.N.A. [#6] taking care of her was not good and she would like to file a complaint...." In a statement dated 10/20/11, L.P.N. #5 indicated, "... Worked Medicare unit the		means to ensure ongoing compliance, all future facility investigations, whether valid or invalid, will be reported to the State Board of Health and appropriate officials.4. As a means of quality assurance, the Administrator or designee will review any/all investigations conducted with the Quality Assurance Committee to ensure that all investigations are thorough and are reported to the proper officials.2.) 1. On 1/25/2012, pain medication was prescribed and implemented for Resident #49.2.There were no other residents affected.3.As a means of ongoing compliance the Pain Policy and Procedure has been reviewed and updated, with the approval of the Medical Director. Mandatory nurses in services are scheduled during the week of February 13th-17th to review the pain policy and procedure.4. As a means of quality assurance, the medical records consultant will quarterly audit charts for nursing documentaion and assessments of pain. Audits will be reviewed with the Quality Assurance committee for the next 6 months. Ongoing audits will not be necessary if 100% compliance is met for the 6 months.	

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	night of October 19th and 20th. My aides were [C.N.A.'s name--#6] and [C.N.A.'s name--#8]; we were short one aide. During A.M. medication pass, [Resident #11's name] said to me that she wanted to know who she should make a complaint to. I assured her that anything she said to me would be passed along to management. She stated that "That girl she had last night was loud and rough"...." In a document titled "Conversation with [Resident's name] 10/20/11" indicated the Social Services Director and the Resident Services Director [RSD] interviewed the resident. The document indicated "... 2.) RSD asked if there was any caregiver that she had that she (the resident) was uncomfortable with that person providing her care. 3.) Resident #11 replied "Yes" and stated that the person who took care of her last night was not good and she had also taken care of her on Saturday and Sunday night. 4.) Last weekend this C.N.A. per resident had taken her to the BR (bathroom) and then put her back in bed. Resident shared that she put her call light on 3-4 hours later and when the aforementioned C.N.A. came in she shook her fist at the resident, took the call light away and left the room without helping the resident. Resident said she had no choice but to wet the bed... 7.) Last night, 10/19/11, the C.N.A. in			

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	question worked again. When she came in the room one time she threw the call light in the corner. Resident stated "I couldn't get it" ... 8.) "This C.N.A. got me up in my W/C (wheelchair). It hurt when she sat me down. She slammed me in the chair. It hurt. I don't deserve to be treated that way." Resident shared that her back already hurt from a fall at home, but felt it was worse now after the C.N.A. had "slammed her" in the W/C...." The record for Resident #11 was reviewed on 1/25/12 at 12:30 P.M. Diagnoses included, but were not limited to, history of urinary tract infection, delirium, coronary artery disease and history of falls. A document titled "Hoosier Village Health Center Social Service M.D.S. (Minimum Data Set) Documentation," dated 10/13/11, indicated the resident was alert and oriented. A Social Service note, dated 10/20/11, indicated "Resident is alert and oriented and able to voice her concerns.... Resident complained to therapy about rough treatment by night staff.... Resident stated took very long time to respond to call light for toileting. Came in shook fist saying "what do you want." Resident stated when she helped her into the chair			

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	she let her sit down too hard...." In an interview on 1/25/12 at 9:30 A.M., the Administrator indicated she did not report the incident to the Indiana State Department of Health (ISDH) because she believed the incident to be a grievance. She indicated they did do an investigation, interviewed staff and a few other residents about the resident's complaint. The facility provided their abuse policy on 1/24/12. The policy, titled,"Reporting/Response of/To Abuse" included, but was not limited to, the following information: "1. The Administrator or designee will report any allegation of abuse... Procedure:...Indiana State Department of Health will be notified by fax within 24 hours of allegation....Written notification/report will be sent to ISDH within 5 days of allegation...." 3.1-28(a)(c) 3.1-37(a) QUALITY OF CARE 2. (a) Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and			

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	psychosocial well-being in accordance with the comprehensive assessment and care plan. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to assess or provide pain control for 1 of 4 resident's reviewed for pain control. [Resident #49] Findings include: Record review for Resident #49 was completed on 1/24/12 at 9:45 A.M. Diagnoses included, but were not limited to, depression, failure to thrive, and generalized pain. A pain assessment dated 11/25/11 indicated Tylenol 1000 mg T.I.D. [three times a day] scheduled. No c/o (complaints) of discomfort at this time...." A M.D.S. [Minimum Data Set] assessment, dated 12/6/11, indicated the resident was severely cognitively impaired and that she had a diagnosis of generalized pain. The pain portion of the M.D.S. indicated the resident reported occasional pain and rated pain as mild pain.			

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	The Director of Nursing indicated a Care Plan dated 6/24/20 was supposed to be dated 3/31/09, with update of 12/6/11. The Care Plan addressed a problem of "Potential for pain related to hx. (history) of falls and fractures." The goal was listed as: "Resident will verbalize having pain controlled as evidenced by sleep intervals of 4-6 hrs [hours] during the night and no acute c/o [complaints] of pain that are not controlled with present Rx. [medication] next 90 days...." Nurses notes indicated: 12/14/11 at 10:15 A.M.--".... This nurse spoke with Nurse Practitioner in regards to res. [resident] refusing meds. V.O. [verbal order] received to discontinue all scheduled meds since they are OTC (over the counter)...." 1/6/12 at 4 P.M.--".... Becomes very resistant when staff turns her when she is in bed and frequently yells out 'OW, OW'. Tx [treatment] to open area on sacrum (bottom) done per orders...." 11 P.M.--".... Yells out and becomes resistive during care...." 1/8/12 at 2 P.M.--".... Continues to be resistive with care and yelling when turned and repositioned...."			

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	1/9/12 at 11:15 A.M.--".... Toileted frequently with assist from staff. Yells out 'OW, OW' when transferring from chair to bed. Frequently yells out " help me, help me" when sitting in room...." 1/10/12 at 10:35 A.M.--".... Tx to open areas on sacrum and buttocks. Very resistant. Yelling out continuously 'help me, help me'...." 1/13/12 at 6 A.M.--".... Continues to yell when turned and repositioned. Resistive during repositioning...." On 1/25/12 at 2:05 P.M., Resident #49 was observed during wound care treatment. The resident was yelling "Oh ow, my bottom," and stating " help me, help me." In an interview on 1/25/12 at 2:10 P.M., the Wound Nurse Consultant indicated she had been caring for the resident's sacral wound since 1/4/12, and that the resident was started on Roxanol [a morphine pain medication] 5 mg. on 1/25/12 for pain, to be given prior to the wound care. She indicated she had seen quite an improvement in the behavior of the resident--she was more complaint with the wound treatment and not yelling out so much--since the pain medication had been started.			

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	In an interview on 1/26/12 at 10:15 A.M., the Administrator indicated Resident #49's yelling out was a behavior. She was given the opportunity to submit any behavior monitoring and intervention documentation for the behavior of "yelling out." She was also given the opportunity to submit any further pain assessments or interventions. At the final exit on 1/27/12 at 11:30 A.M., no additional documentation related to behaviors with interventions, or pain assessments with interventions, was provided for review. 3.1-37(a)			

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R0157	n) The facility shall develop, adopt, and implement written policies and procedures on cleaning, disinfecting, and sterilizing equipment used by more than one (1) person in a common area. Based on observation and interview, the facility failed to ensure the floors in the dry storage area and behind the steamer, grill, stove, fryer, and the top of the steamer were free of dust and debris. This had the potential to impact 73 of 73 residents who received meals prepared in the facility residential kitchen. Findings include: During the initial tour of the kitchen with the Director of Food Services, on 1/23/12 at 11:15 A.M., the floor of the dry storage room, under the shelves and along the walls, had a dark residue and debris. In the food preparation area, the top of the steamer was noted to have a dark yellow substance, dust and debris. During an interview with the Director of Food Services, on 1/23/12 at 11:20 A.M., she indicated the floor of the dry storage had areas under the shelves that appeared dark and the top of the steamer would be cleaned.	R0157	1.There were no residents affected. 2.The floors in the dry storage area and behind the steamer, grill, stove, fryer and top of the steamer were cleaned the same day and therefore no residents were affected. 3.The facility has reviewed and updated the dietary cleaning schedule. All dietary staff will be inserviced on the updated cleaning schedule the week of February 13th-February 17th. 4. As a means to ensure ongoing compliance, the kitchen supervisor or designee will monitor the cleaning duties daily. The Director of Dining Services or designee will audit the cleaning schedule weekly. All audits will be reviewed with the Quality Assurance Committee for the next 6 months. Ongoing audits will not be necessary if 100% compliance is met for the 6 months.	02/17/2012

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R0408	(c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on record review and interview, the facility failed to ensure a Resident had a chest x-ray prior to being admitted to the facility. This impacted 1 of 7 Residents reviewed for chest x-rays prior to being admitted to the facility in a sample of 7. (Resident #201) Residential findings include: The clinical record of Resident #201 was reviewed on 1/24/12 at 12:50 P.M. Resident #201 was admitted to the facility on 4/5/11. A review of the immunization record indicated a chest x-ray was done on 7/29/11. This was three months after the Resident was admitted to the facility. During an interview with the Healthcare Facility Administrator, on 1/27/12 at 11:00 A.M., she indicated a chest x-ray could not be found for Resident #201 prior to admittance to the facility.	R0408	1. There were no adverse effects from Resident #201 having a chest x-ray 3 months after admission to the Residential building. 2. An audit was conducted and there were no other residents without an admission chest x-ray on their chart. Therefore, no other residents were affected. 3. As a means to ensure ongoing compliance, the medical records clerk or designee will perform monthly chart audits to ensure that each new resident has an admission chest x-ray on the chart. 4. As a means of quality assurance, medical records or their designee will notify the Director of Nursing monthly for any noncompliance	02/10/2012

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R0410	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.			
	Based on record review and interview, the facility failed to ensure a new Resident had the second step of the two-step Tuberculin skin testing. This impacted 1 of 7 Resident reviewed for Tuberculin skin testing in a sample of 7. (Resident #87) Residential findings include: The clinical record of Resident #87 was reviewed on 1/23/12 at 2:25 P.M. Resident #87 was admitted to the facility on 3/26/11. A review of the immunization record	R0410	1. Resident #87 received any annual PPD on 10/11/12 during the facilities annual resident health fair. The results were negative and there were no adverse effects for resident #87. 2. An audit has been conducted and there were no other residents without a second step PPD on their chart. Therefore, no other residents were affected. 3. As a means to ensure ongoing compliance, the medical records clerk, or designee, will perform monthly chart audits to ensure that a second step PPD has been completed and documented on each new resident. 4. As a means of quality assurance, the medical records clerk, or designee, will	02/10/2012

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	indicated a tuberculin skin test was done on 3/22/11 and read on 3/25/11. There was no indication the second step of the two-step tuberculin skin test was done. During an interview with L.P.N. #4, on 1/24/11 at 11:10 A.M., she indicated the second tuberculin skin test, on the two-step testing, was not done.		notify the Director of Nursing monthly for any noncompliance.	